

DENVER PUBLIC SCHOOLS
DIVISION OF STUDENT SERVICES
Multilingual Assessment Services Team (MAST)
Referral for Initial Evaluation for English Language Learners

Student's Name: _____ Date of Birth: _____ Age: _____ Sex: ☐ M ☐ F

School: _____ Grade: _____ If ECE or Kdg. AM__ PM__ All Day__

General Education Teacher: _____ Room #: _____ **DPS-ID #** _____
Special Education Case Manager: _____ Contact Phone #: _____

Vision Screening date _____ <input type="checkbox"/> pass <input type="checkbox"/> fail	Glasses? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, does this student wear them regularly? <input type="checkbox"/> No <input type="checkbox"/> Yes	Hearing Screening date _____ <input type="checkbox"/> pass <input type="checkbox"/> fail	Hearing Aids? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, does this student wear them regularly? <input type="checkbox"/> No <input type="checkbox"/> Yes
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**STOP!! IF EITHER VISION OR HEARING SCREENING FAILED,
BE SURE FOLLOW-UP HAS OCCURRED FOR THE FAILED ITEMS BEFORE TESTING BEGINS.**

**Complete the following checklist specifying school's responsibilities and
MAST responsibilities for standardized and/or targeted assessment.**

School		MAST	
Speech and Language	_____	Speech and Language	_____
Educational	_____	Educational	_____
Psychological	_____	Psychological	_____
Social Work	_____	Social Work	_____
Health	_____	Health	_____

Referring school is responsible for:

- Obtaining parent permission for testing **ONLY after** MAST referral has been completed.
- Attaching a copy of parent permission/consent to test **with** the MAST referral.

NOTE: reports cannot be entered into ENCORE until an IEP staffing date is set.

Parent Permission/Consent Date _____

60-Day Testing Compliance Date _____

90-Day Eligibility Meeting Compliance Date _____

Eligibility Meeting Date Set for: ____ / ____ / ____ :

Return this form via school mail to: MAST; Fox Street-2nd Floor South.

*Confirmation form will be sent within 10 school days of receiving referral. If not received, contact MAST at 720-423-8065.

DATE SENT TO MAST _____

FOR MAST OFFICE USE ONLY

DATE RECEIVED _____

FMP# _____

Multilingual Assessment Services Team (MAST)
Referral for Initial Evaluation for English Language Learners

Student Name _____ **ID#** _____

<p>1. Parent(s)/Legal Guardian(s)</p> <p>Father: _____ (work) _____ (cell) _____</p> <p>Mother: _____ (work) _____ (cell) _____</p> <p>Home Address: _____ _____</p> <p>Home Phone: _____</p>	<p>2. Was student born in the USA? <input type="checkbox"/> Yes. Where? _____ <input type="checkbox"/> No. How long has student lived in the USA? _____</p> <p>3. Has this student ever received... literacy instruction in L₁? <input type="checkbox"/> No <input type="checkbox"/> Yes content instruction in L₁? <input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p style="text-align: center;">When? _____</p> <p style="text-align: center;">Where? _____</p> <p style="text-align: center;">For how long? _____</p>	<p>4. Language(s) Spoken <u>By</u> Student _____ Father _____ Mother _____ Siblings _____ Primary Care Taker _____</p> <p>5. Language(s) Spoken <u>With</u> Father _____ Mother _____ Siblings _____ Primary Care Taker _____ Teacher _____ Peers _____</p>
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PLEASE WRITE OUT ANY INFORMATION / INTERVENTIONS THAT HAVE BEEN USED.

6. Which of the following areas impact this student in the educational setting? How?

Please attach supporting and **SIT** information regarding this issue and **GIVE A BRIEF EXPLANATION.**

<input type="checkbox"/> Educational	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other <input type="checkbox"/> Not a Concern _____

<input type="checkbox"/> Speech/Language	<input type="checkbox"/> English <input type="checkbox"/> Spanish <input type="checkbox"/> Other <input type="checkbox"/> Not a Concern _____

<input type="checkbox"/> Social/Emotional/Adaptive	<input type="checkbox"/> Not a Concern _____

<input type="checkbox"/> Cognitive	<input type="checkbox"/> Not a Concern _____

<input type="checkbox"/> Physical/Health/Motor	<input type="checkbox"/> Not a Concern _____

<input type="checkbox"/> Behavioral	<input type="checkbox"/> Not a Concern _____

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